

FISCAL FOCUS

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May 2019

Illinois' Massive Shift to Managed Care

INSIDE STORIES:

Cover Story, Illinois' Massive Shift to Managed Care	3-9
Comptroller's Legislative Agenda	10-11
IOC Launches Interactive PAR Portal	12
Minimum Wage in Illinois	13
Bill Backlog Update	15



SUSANA A. MENDOZA
STATE OF ILLINOIS COMPTROLLER

From the Comptroller —

I am excited to announce the relaunch of *Fiscal Focus*, a periodic magazine offering key state fiscal facts and in-depth articles about timely issues, as part of the ongoing transparency efforts of the Comptroller's Office.

As Comptroller, I have worked to make this office more open than ever before. My Transparency Revolution has resulted in several new laws that opened the books on state government, so taxpayers and policymakers can have a better awareness of the fiscal challenges the state faces.

Thanks to the Debt Transparency Act (DTA), my office now offers monthly reporting on the state's bill backlog. Before the DTA, the public had no way of knowing how much Illinois actually owes in overdue bills because state agencies didn't disclose what bills they had on hand.

The monthly reports required under the DTA also revealed, for the first time, that the budget impasse cost taxpayers over \$1 billion in late payment interest penalties. The reports have been cited by lawmakers and both the current and previous administrations as a crucial source of fiscal information as they craft a state budget. You can find the DTA reports at <https://illinoiscomptroller.gov/DTA>.

In addition to the DTA, I championed new laws that require governors to budget for late payment interest penalties and to pay their staff members from the appropriations for their own offices, instead of offshoring them onto the budgets of state agencies.

The return of *Fiscal Focus* is a natural continuation of this Transparency Revolution. While Illinois comptrollers began issuing regular fiscal reports from the office's earliest days in the 1970s, the publication of *Fiscal Focus* started under former Comptroller Loleta Didrickson's administration in 1995 and continued under comptrollers Dan Hynes and Judy Baar Topinka, but lapsed before I took office.

The renewed *Fiscal Focus* will highlight some of the transparency information my office collects, inform readers on important policy topics and keep them up-to-date on developments at the Comptroller's Office.

This issue of *Fiscal Focus* provides comparisons of our state's minimum wage with the minimum wages in other states; highlights the interactive Public Accountability Report, a new transparency tool from the Comptroller's Office; and offers an in-depth look at Illinois' shift to using managed care organizations to administer the state's Medicaid program, which is one of the largest areas of spending in state government.

In fiscal year 2010, less than 3% of the Illinois Department of Healthcare and Family Services' spending on care for the year went to managed care organizations. In fiscal year 2019, it is estimated that number will grow to more than 70% of care expenditures. This substantial shift has implications for transparency, care for some of Illinois' most vulnerable residents, and the state's overall health care system.

As I've traveled Illinois, meeting with state vendors who suffered through sparse or no payments during the two-year budget impasse, I heard from them what a hardship that is as they try to keep their doors open. I've offered what help my office can provide: in some cases, advancing funds so an organization would not miss payroll, and employees could stay on the job.

I've also worked to elevate these stories so people know the state's bill backlog, which stands at \$6.162 billion at the time of publication, isn't just a number on a spreadsheet. It has a real impact on people's lives and on businesses throughout our state. I plan to use *Fiscal Focus* to highlight some of those stories.

I hope you find *Fiscal Focus* useful and informative. Your comments about this and other publications from this office are always welcome. You can contact us at 800-877-8078 or info@illinoiscomptroller.gov.

You can also provide feedback through social media. You can find the Office of the Comptroller on Facebook: [@ILComptroller](#), Twitter: [@ILComptroller](#), and Instagram: [@ilcomptroller](#).



A handwritten signature in black ink that reads "Susana A. Mendoza". The signature is written in a cursive, flowing style.

Susana A. Mendoza
Illinois State Comptroller

Illinois' Massive Shift to Managed Care

Illinois lagged behind national trends when it first tested the waters of managed care about a decade ago. But in recent years, the state took the plunge — signing on to managed care for 80% of Medicaid patients.

In fiscal year 2010, the Illinois Department of Healthcare and Family Services (HFS) spent \$251 million on managed care organizations, just over 2.58% of its entire expenditures on care for the year. In fiscal year 2019, it is estimated that this expenditure will grow to \$10.8 billion, more than 70% of HFS's care expenditures. This could rise as high as \$14 billion in overall state spending.

This substantial shift in spending has implications for transparency, care for some of Illinois' most vulnerable residents, and the state's overall health care system. (A legislative working group is currently considering dozens of proposals to change the way Medicaid is regulated in Illinois.)

This expansion of managed care will continue for the foreseeable future. In August 2017, HFS announced new contracts with seven managed care organizations (MCOs) to expand the percentage of Illinois Medicaid recipients under managed care from 64.5% to 80%. Geographic coverage would also expand from 30 Illinois counties to all 102.

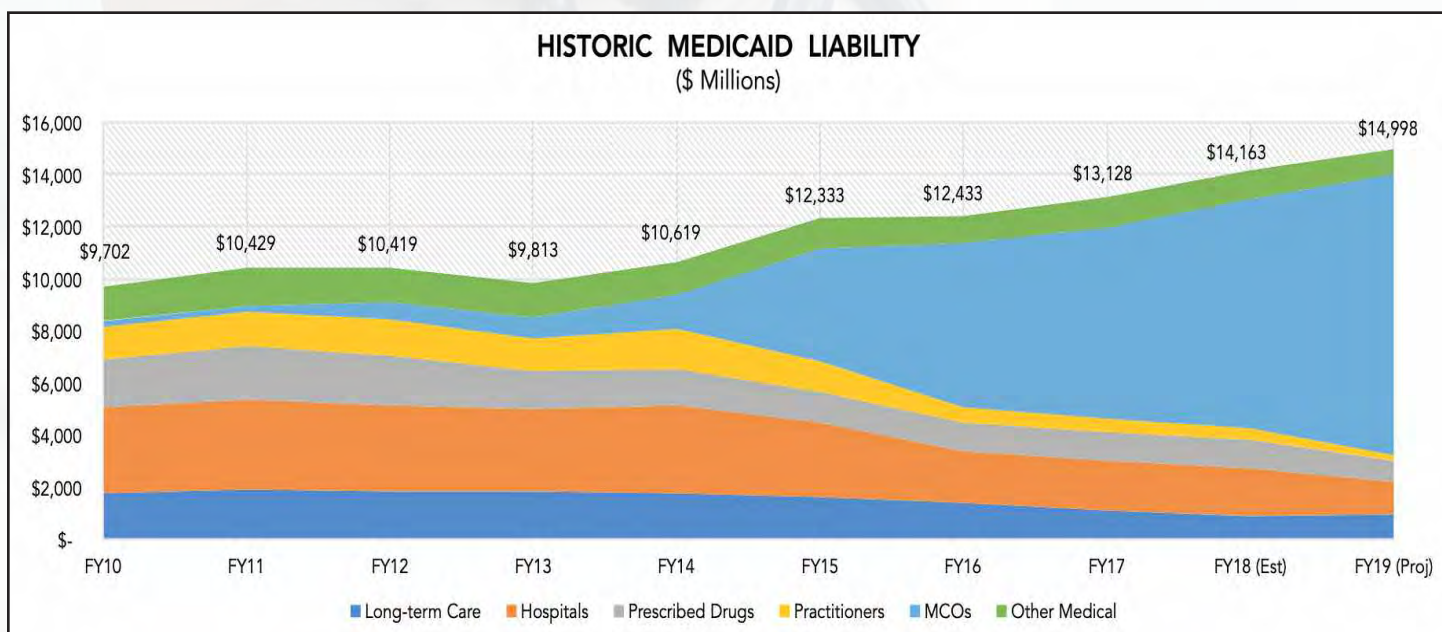
The total value of the seven new managed care contracts was \$63 billion, making this recent managed care expansion initiative—also known as HealthChoice Illinois—the largest procurement in state history.

Given the scale of this shift, it is important for residents and policymakers to understand the history of managed care in Illinois, as well as its impact on state budgets and policy in the future.

This substantial shift in spending has implications for transparency, care for some of Illinois' most vulnerable residents, and the state's overall health care system.

What is Managed Care?

Managed care in the United States is rooted in the 1960s and 1970s with the expansion of government managed health insurance. As part of President Lyndon Johnson's



* HFS numbers that reflect total General Revenue and related funds liability

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“Great Society,” Congress passed the Social Security Amendments of 1965, which created a national health insurance program for seniors (Medicare) and low-cost medical services for low-income Americans (Medicaid).

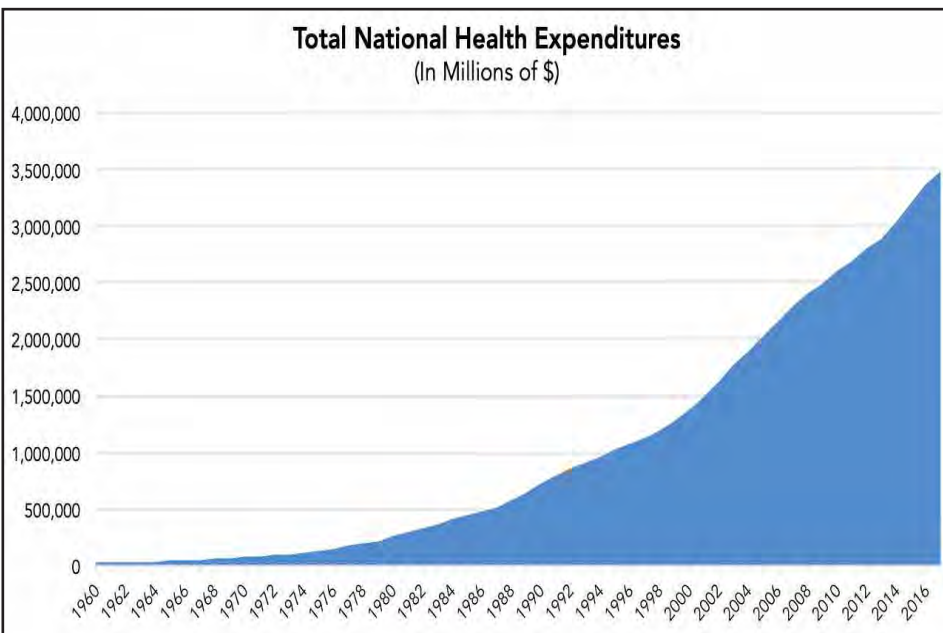
To pay for these services, states would pay health care providers directly, with monetary assistance coming from the federal government. This process is known as fee-for-service.

In 1973, Congress passed the Health Maintenance Organization Act, which amended the Public Health Service Act to allow for-profit entities to provide medical care services. Previously, medical care was provided by non-profit entities. The new law allowed for the proliferation of health maintenance organizations (HMOs), which established networks of providers to cover the health care needs of individuals.

Although the basic concept of HMOs existed prior to 1973, through prepaid private insurance providers like Blue Cross Blue Shield, the change in law led to the expansion of HMO usage in the 1980s as a way to curb rising medical costs.

HMOs achieved savings by pushing providers to discount their rates and linking networks of providers to make the system more efficient. However, by the 1990s, HMOs had fallen out of favor following protests that the systems were generating cost savings by denying care.

But the 2000s witnessed a resurgence of managed care at the state level. MCOs contracted with states to provide Medicaid services through a risk-based system for a pre-set premium, known as a capitation payment. This system is called “risk-based” because MCOs are at financial risk for the services outlined in their Medicaid contracts with the states, since they are responsible for contracting with providers directly. If the price contracted with the provider is greater than the annual capitation payment, then the MCO would absorb the loss.



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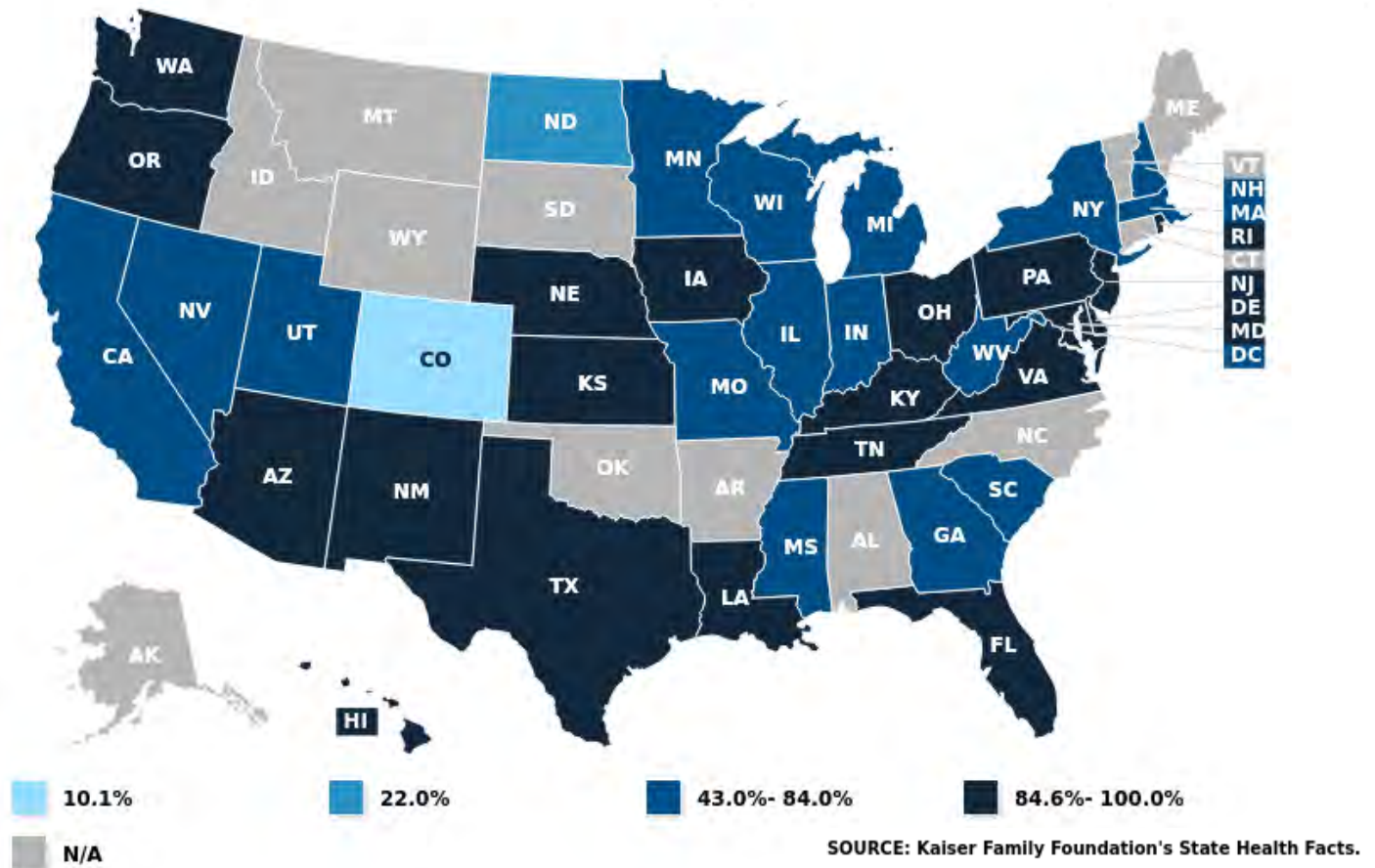
Who is covered by Medicaid in Illinois?

Historically, Medicaid has covered three broad groups of low-income individuals: families, individuals age 65 and older, and individuals under 65 with disabilities.

In 2010, Congress passed the Affordable Care Act (ACA), which, among other health care changes, expanded Medicaid eligibility for states willing to participate. The federal government also offered to pay 100% of the costs of Medicaid expansion for participating states from 2014 to 2016, then stepping down to 95% of costs in 2017, 94% in 2018, 93% in 2019, and 90% in all subsequent years. Illinois law requires benefits to this group to cease if Illinois’ federal match falls below 90%.

Income eligibility ranges from state to state, but a minimum threshold is established by the federal government. In Illinois, Medicaid covers adults who are up to 133% of the federal poverty level (plus a 5% income disregard) and gives additional coverage to pregnant women who are up to 213% of the federal poverty level and children who are up to 147% of the federal poverty level.

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Share of Medicaid Population Covered under Different Delivery Systems: Percent of Medicaid Population in MCO, as of July 1, 2018

States are required to pay actuarially sound rates under this system, per federal law. MCOs must follow federal and state requirements that cover enrollment and disenrollment procedures, beneficiary grievance and appeals processes, access to care, and regular reporting requirements.

As of 2018, 39 states utilize MCOs for some part of their Medicaid programs, with 28 states (including Illinois) having at least 80% of their systems under MCOs.

First Major Managed Care Expansion in Illinois

In comparison to other states, Illinois was relatively late expanding into managed care. However, starting in 2010, with managed care spending representing a small portion of state Medicaid spending, the General Assembly passed a series of laws that would begin to move Illinois toward becoming a majority-managed care state. At the time, managed care represented less than 3% of Medicaid spending.

The first major legislative push came in January 2011 with Public Act 96-1501, which grew out of a desire by the

Legislature to show an ability to rein in state expenditures while approving an income tax increase.

A Senate Special Committee on Medicaid Reform recommended care coordination to maximize efficiency, and the majority of the Legislature agreed. Public Act 96-1501 required that by January 1, 2015, at least 50% of all Medicaid recipients eligible for full benefits would be enrolled in care coordination.

It was envisioned that MCOs would facilitate this care coordination. The state would pay based on the patient population, usage rates, medical records, and general performance related to health care outcomes.

Additionally, verification standards were tightened to cut down on waste and fraud—default termination of coverage with no response to 60-day notice of eligibility ending, no presumption of eligibility for adults except where mandated by federal law, changes to All Kids program eligibility, etc. These changes were projected to save the state \$500 million over four years.

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In Illinois, seven major groups are covered under Medicaid or Medicaid-attached programing:

Mothers and Children: Pregnant women and their children up to one year of age in families with monthly income at or below 213% of the federal poverty level. Children under one year of age are eligible at any income level if Medicaid covered the mother at the time of the child's birth.

Aid to Aged, Blind, and Disabled (AABD): Seniors, persons who are blind and persons with disabilities with monthly incomes of up to 100% of the federal poverty level and limited other resources.

ACA Adults ("newly eligible"): Adults ages 19-64 who are not parents raising children and who have monthly incomes of up to 138% of the federal poverty level.

FamilyCare Assist: Parents and caretaker relatives raising dependent minor children. To be eligible, adults must have family monthly incomes at or below 138% of the federal poverty level.

Workers with Disabilities: Persons with disabilities who work and have earnings up to 350% of the federal poverty level who buy in to Medicaid by paying a small monthly premium.

Patients with Breast or Cervical Cancer: Individuals under age 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by the Department of Public Health. Medicaid covers treatment for individuals with monthly incomes up to 200% of the federal poverty level.

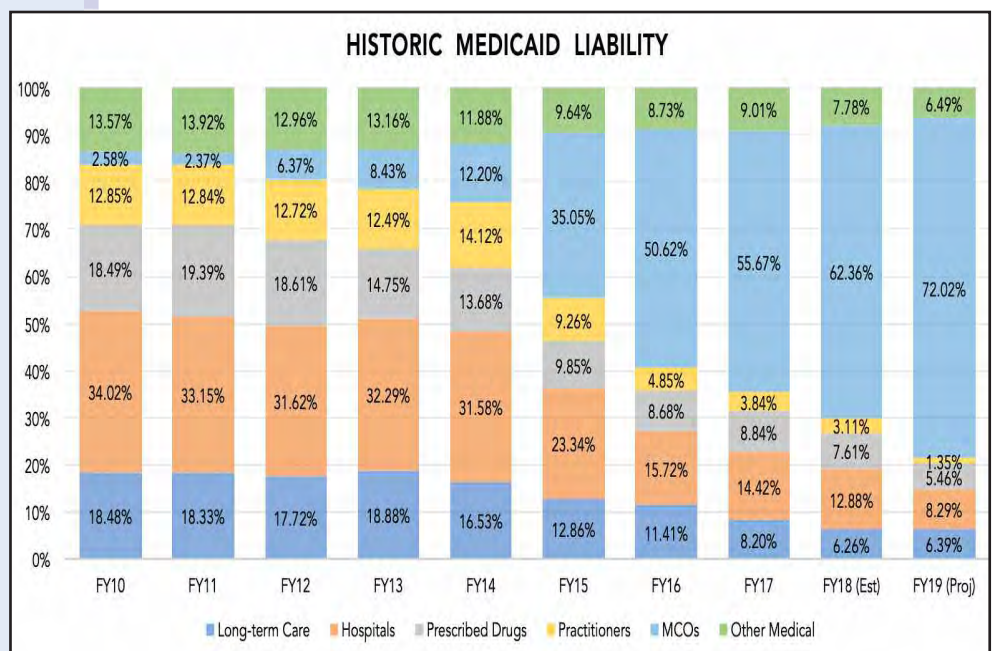
Department of Children and Family Services: Designed for children in DCFS custody, those placed in subsidized guardianship and adoption assistance arrangements and former DCFS youth in care ages 19-26 who were enrolled in Medicaid when they aged out of foster care. There are no income or resource limitations.



Comptroller Susana A. Mendoza visits nursing homes, hospitals, and health care facilities all over the state. On these visits, she hears from administrators and staff about their concerns, including delayed payments, and she talks with patients about their life circumstances and the quality of their care.

In 2012, HFS projected that medical assistance liabilities would grow by 5% every year from fiscal year 2012 to fiscal year 2017. Federal stimulus dollars that had been supplementing state medical expenditures ended in 2012, and the projected Medicaid bill backlog was pegged to increase from \$1.7 billion in fiscal year 2012 to \$21 billion by fiscal year 2017.

A bipartisan working group, called the Legislative Medicaid Advisory Committee, was formed to reduce the Medicaid liability by \$2.7 billion. The work from this group eventually became the Save Medicaid Access and Resources Together (SMART) Act, which passed in 2012. The new law contained eligibility restrictions and cost-sharing measures. The



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SMART Act limited optional services, cut rates to nursing homes and instituted new payment benchmarks for hospitals. Some of these cost savings in the SMART Act have since been changed or repealed.

Like with the previous legislation around Medicaid reform, the SMART Act also attempted to combat fraud and waste within the system. The act created more stringent monitoring standards for vendors, allowed HFS to collect interest on overpayments and required the inspector general for HFS to conduct more system audits.

The SMART Act also included the implementation of an Integrated Eligibility System (IES), which is a benefit eligibility system that is designed to accommodate Affordable Care Act (ACA) rules. The Center for Medicaid and Medicare Services offered a 90% federal match as incentive for states to develop these systems.

Since the SMART Act passed, other major reforms to the Medicaid system have been taken up by the General Assembly, including Public Act 98-0651, which placed further regulations on MCOs to ensure each system offers adequate services, especially in relation to their hospital provider network.

Largest Procurement in State History

In his 2016 State of the State address, then-Governor Rauner unveiled a plan to remake the state's Medicaid



Illinois Comptroller Susana A. Mendoza provided testimony to the House Human Services Committee in May 2017 about the lack of transparency around the procurement process for the state's recent managed care expansion.

system by moving more Medicaid recipients to managed care. Rauner said care coordination would save the state money through increased efficiency and reductions in fraud and abuse.

As a result, HFS put out a request for proposals to expand MCO coverage of Medicaid from 30 counties in Illinois to all 102 counties, and from 64.5% of the Medicaid population to 80%.

Transferring the management of the state's Medicaid program to a private system has meant less government insight into the system overall.

In May 2017, the Office of the Comptroller issued a report raising concerns about the lack of transparency around the procurement process for the managed care expansion. Comptroller Susana A. Mendoza conveyed these concerns in a letter to the Rauner administration and provided testimony on the report to the House Human Services Committee.

In August 2017, HFS announced six MCOs (Blue Cross Blue Shield of Illinois, Harmony Health Plan, IlliniCare Health, Meridian Health Plan, Molina Healthcare and CountyCare Health Plan) had been awarded four-year managed care contracts. Later, a seventh MCO (NextLevel Health) would also receive a contract. The seven MCOs received four-year contracts worth a total of \$63 billion, the largest procurement in state history.

The expansion of MCO coverage in Illinois, called HealthChoice Illinois, was originally intended to be divided into three distinct phases.

The first step was to transition beneficiaries who were currently enrolled in an MCO and reside in a county where managed care already exists. HFS sent transition letters in October 2017 to these enrollees. For Phase I enrollees, coverage under the new system began January 1, 2018. Beneficiaries then had a 90-day switch period (January 1, 2018 to March 31, 2018) to change MCOs.

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Next, HFS enrolled beneficiaries who resided in counties that did not have managed care and were not currently enrolled in an MCO, as well as newly eligible Medicaid beneficiaries and some populations previously excluded from managed care. HFS mailed enrollment letters to these beneficiaries between a transition period of January 8, 2018 and February 16, 2018. All beneficiaries new to managed care had 30 days from the date of the enrollment letter to select a Primary Care Physician (PCP) and an MCO. For Phase II enrollees, coverage under the new system began April 1, 2018. Beneficiaries then had a 90-day switch period to change MCOs.

The final phase – to conduct statewide enrollment of DCFS Youth and Special Needs Children – was originally expected to occur around July 1, 2018, but has been significantly delayed.

Managed Care Today

Over the past 10 years, managed care has moved from a health care expenditure representing less than 3% of HFS's care expenses to a \$14 billion-plus annual behemoth. The goal of increasing efficiency and cutting down on waste through care coordination has been the impetus for this large managed care expansion.

However, transferring the management of the state's Medicaid system to a private management system has meant less government insight into the system overall. Two audits conducted by the Illinois Auditor General, one in January 2018 of MCOs and one in March 2018 of HFS, revealed inadequate oversight of MCOs by HFS. Findings included not

tracking MCO medical loss ratios (MLRs). Lawmakers subsequently passed a law (Public Act 100-0580) to add more transparency to the MCO system.

While the new MCO expansion was progressing, issues with the state's Integrated Eligibility System were uncovered. In December 2017, 30,000 Illinoisans were unable to receive their SNAP benefits. Officials stated the issue was due to the rollout of Phase II of IES, stemming from a slowdown in determining eligibility. Additional issues were highlighted in the summer and spring of 2018, this time dealing with long-term care determinations.

On March 30, 2018, the Northern District of Illinois Federal Court ordered in *Koss v. Norwood* that the state comply with federal regulations regarding applicants for long-term care benefits. DHS and HFS were ordered to issue provisional eligibility to applicants that had been pending longer than federal guidelines allowed.

On June 28, 2018, the Office of the Comptroller published a report on

The audit confirmed the concerns raised by the Comptroller's report, finding there had been significant errors in data collection, reporting, and monitoring.

Medicaid long-term care determinations and pending legislation that further highlighted this issue. The report pointed to a 142.9% spike in long-term care admissions pending over 90 days, from December 2017 to May 2018. As a result of this spike in long-term care determinations, the Legislature

How does the federal Medicaid match work?

In addition to the ACA federal coverage, the federal government pays a match rate based on a formula called the Federal Medical Assistance Percentage (FMAP). The formula uses the state per capita personal income measured against the national average.

The FMAP must be greater than 0.50 and cannot be greater than 0.83.

Illinois' FMAP typically hovers around 50%. Therefore, generally, for every \$1 that Illinois spends on Medicaid-eligible services, the federal government returns about \$0.50.

This federal return then can be used again on Medicaid-eligible services and generate a \$0.25 match, which can keep being wound down until there are no more Medicaid-eligible bills.

passed Public Act 100-1141, which enshrined the provisional authority ordered in *Koss v. Norwood* into law.

Another item highlighted in the Comptroller's June 2018 report was a lack of publicly available data between July 2017 and December 2017. The Office of the Comptroller formally requested this information from HFS on May 25, 2018 but received a response that the data was not available due to data entry catch-up and quality control activities.

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In the wake of these lingering issues, the legislature passed Public Act 100-0380 and Public Act 100-0665, which established performance and compliance audits for long-term care determinations and requested a review of the current program.

On March 14, 2019, the Illinois Auditor General released its report of long-term care determinations from 2015 to 2017.

rate than were being denied under the fee-for-service model or in the commercial insurance setting.

In March 2019, a group of lawmakers and representatives from the state's Safety Net Hospitals held a press conference at the state Capitol, where they said MCOs are denying claims from hospitals across the state at an average of 26%.

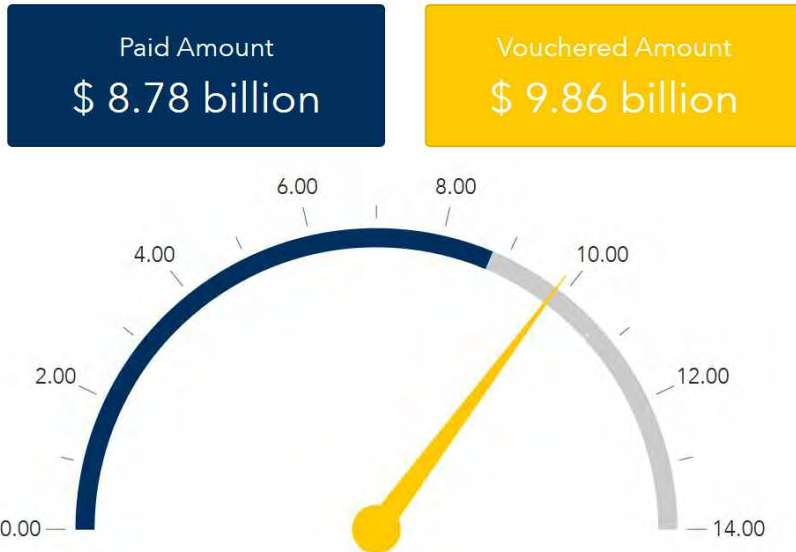
on the passage of an MCO assessment, which the administration projects will generate \$390 million in revenue. The assessment is similar to other MCO assessments in California and Michigan, and is expected to be debated by the Legislature this spring.

As a result of all this discussion on managed care and Medicaid, the General Assembly has formed a working group represented by the four legislative caucuses to review the system holistically. The group is considering several topic areas, including claims denials, eligibility determinations, and payment rates.

Some of the measures before the group include proposals to streamline the process for seeking prior approval for procedures, create a standardized list of information providers must submit to support a claim, update patient rosters in a timely manner, and adopt uniform definitions on things like what constitutes a denial of a claim.

Lawmakers are also considering a proposal that would require the state to reinstate all long-term care residents whose Medicaid applications were rejected or denied, if the state failed to notify the facility where they reside, as required by state law. This proposal is meant to address some of the problems with eligibility determinations that took place under the Rauner administration.

Ultimately, the goal of the working group will be to bring more transparency and accountability to a program that provides care for millions of residents and represents an increasingly significant state expenditure. ■



The audit confirmed the concerns raised by the Comptroller's June 2018 report, finding there had been significant errors in data collection, reporting, and monitoring within the system, which had caused the system to be in violation of federal guidelines.

In addition to the issues the Office of the Comptroller highlighted about data collection and transparency, lawmakers and care providers have raised concerns about payments from MCOs.

Medical equipment providers and other health care providers have asserted that lower prices offered to them by MCOs were inhibiting their ability to continue to provide Medicaid services.

Additionally, some providers have complained that MCOs are slow to pay and/or are denying claims at a higher

The Office of the Comptroller does not have access to the data needed to independently confirm MCO denial rates. Furthermore, MCOs, providers, and HFS do not appear to have a universally agreed upon benchmark for what constitutes a denial.

Outlook for Managed Care

Due to these and other issues, more than 40 legislative proposals dealing with managed care have been introduced during the General Assembly's 2019 spring session, including House Bill 2117/Senate Bill 1238, an initiative by the Office of the Comptroller to strengthen transparency within the managed care cash-flow process.

Additionally, the Governor's fiscal year 2020 budget proposal partially relies

Comptroller's Legislative Agenda Focuses on Transparency and Financial Stability for Illinois Residents



Illinois Comptroller Susana A. Mendoza's 2019 legislative agenda will bring transparency to billions of dollars in state payments that go through Illinois' Medicaid program and extend key financial tools to more Illinoisans.

Last year, Illinois implemented a massive expansion of Medicaid managed care. The \$63 billion procurement was the largest in state history. Although Illinois is relying on managed care organizations (MCOs) to administer the bulk of the Medicaid program, providers and policymakers have relatively little information about when providers, like doctors and nursing homes, can expect payment from MCOs for the treatment they provide their patients.

"As the state's chief fiscal officer, I cannot see what happens to billions of taxpayer dollars after my office releases them to the MCOs. I frequently hear from providers whose Medicaid payments have been delayed. They often have no idea when their payments might come," said Comptroller Mendoza. "Providers, like nursing homes in rural and low-income communities, rely on reimbursements from MCOs to keep their doors open and serve vulnerable populations. They deserve transparency when it comes to how and when these payments are made — and so do taxpayers."

The MCO Transparency Act would require MCOs to publish provider payment information on their websites every quarter, including the total number of claims received by the MCO for that quarter, the amounts paid to providers and when those payments were made. MCOs would also be required to disclose when the claims for payments were received and when the service for the payment was rendered.

State Representative Natalie Manley, D-Joliet, is sponsoring the proposal (House Bill 2117) in the House, and state Senator Laura Fine, D-Glenview, is the sponsor of the Senate version (Senate Bill 1238). Groups representing providers across the state, including pharmacists, nursing homes, ambulance services and safety net hospitals, support the legislation.

"Providers offering care to sick children and others in need are struggling because of payment delays, and they have no reliable way of knowing when their next payment is coming," Senator Fine said. "As more and more state dollars are filtering through MCOs, it just makes sense to require transparency and give some predictability to our health care providers."

The MCO Transparency Act is a natural outgrowth of Comptroller Mendoza's Debt Transparency Act, which provides sunshine to unpaid bills held by state agencies, and her other reforms that require transparency on offshored Governor's staff, the state's Vendor Payment Program and the state's obligations to pay late payment interest penalties.

The Comptroller also instituted a new annual Milestone Report which must be filed for all state Information Technology contracts over \$5 million. Agencies will have to report work done and deadlines by which projects are due to be completed.

Saving Illinois from predatory lenders

Comptroller Mendoza's legislation to give more Illinoisans access to banking services through a program called Bank On Illinois passed the Senate unanimously.

More than one-fifth of Illinois households conducts its financial business outside the traditional banking system, according to a 2015 report from the Federal Deposit Insurance Corporation (FDIC). Unbanked individuals often take their financial business to predatory lenders such as auto title lenders, check cashers, payday lenders and pawnshops, which charge exorbitant fees for basic services, like check cashing, and high interest rates on lending.

"My office offers workshops all over the state that advise people on how to get their finances in order, but many Illinoisans lack access to the basic tools they need to do that,"

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Comptroller Mendoza said. "Many of us take for granted being able to cash a check at our bank, open a savings account to plan for our family's future or secure a loan at a reasonable interest rate. But thousands of Illinoisans don't have these options, and they pay for it in inordinate fees and sky-high interest rates. This legislation will help them break that cycle and offer a second chance to those with troubled financial histories to get back on the right track."

The Brookings Institute found that, on average, a full-time worker who doesn't use traditional retail banking products is charged roughly \$40,000 in lifetime fees.

Lack of access to traditional banking is a problem in both rural and urban areas throughout Illinois. Cook County has a combined unbanked and underbanked rate of 29.6%. Alexander County has a rate of 35.6%, Pulaski County's rate is 32.8% and Macon County's rate is 34.9%.

Senate Bill 1332 will expand access to banking in Illinois by using Bank On, a proven, national model that aims to connect consumers with reliable, affordable, and equitable financial products. Senate Bill 1332 would create a Bank On Illinois program in the Office of the Comptroller. Under this program, the Comptroller would partner with governmental entities, representatives of the community and financial institutions to certify financial products for low-income customers and promote the program throughout Illinois.

Bank On programs certify products that provide fair financial service options such as no maintenance fees, low minimum deposits, low or no overdraft fees and alternative IDs. They also provide secured personal loans — low-risk lending that allows consumers with low credit scores to begin rebuilding their credit.

State Senator Cristina Castro, D-Elgin, introduced the bill in the Senate.

"Many in our state cannot afford or meet the requirements to get a bank account, such as startup fees or a large minimum deposit, or they lack the needed identification or credit score. This leaves them vulnerable to predatory lenders and ends up costing them so much more in the long run," Senator Castro said. "Senate Bill 1332 will shield low-income families from excessive fees and give them the tools they need to help secure their financial futures."

State Representative Debbie Meyers-Martin, D-Olympia Fields, will sponsor the bill in the House. "Families without bank accounts and other basic financial services are continually forced to shell out money to pay extremely high fees and interest rates from predatory service providers. For thousands of Illinois families, this means a seemingly perpetual cycle of poor credit, lack of access to affordable loans, and thousands taken out of their paycheck every year," Meyers-Martin said. "In today's economy, families need the resources modern banking provides to survive and build a better life for their families. Bank On Illinois is a proactive approach to connect people with affordable financial services so they can escape exorbitant fees and provide the financial stability they need to build wealth for themselves and our communities."

Comptroller Mendoza, Senator Castro, and Representative Meyers-Martin are joined in their efforts by banking organizations, community advocates, and local government officials who support Senate Bill 1332. ■



Office of the Comptroller Launches Interactive Public Accountability Report Portal

Comptroller Susana A. Mendoza recently unveiled a new, user-friendly, web-transparency tool, allowing taxpayers and policymakers to track the annual performance of hundreds of state programs.

The Office of the Comptroller places a high priority on the accountability of state government, not only in terms of reporting traditional financial data, but also by evaluating performance to help ensure taxpayer dollars are being used wisely and effectively. The Public Accountability Report (PAR) contains data from state agencies about programs they administer and metrics that measure the performance of those programs.

After 20 years in publication, the PAR is entering an exciting new phase, offering Illinois residents the ability to access agency performance data in an interactive format. The interactive Public Accountability Report makes it easier for the public to access information about state services and programs and an accounting of their effectiveness. It will also increase transparency and cut costs by reducing mailing and publication expenses of printed PARs, which can be up to 300 pages long.

“This is just one of many ways my office brings financial data to the fingertips of those who need it,” Comptroller Mendoza said. “The new digitized Public Accountability Report feature on our website will allow



taxpayers, policymakers, researchers and the press to take a critical look at state programs and determine if taxpayer dollars are being used effectively.”

The goal of the PAR is to make comprehensive information about the results of state government programs available to the public and government officials in an understandable format. The report seeks to inform decision-making on the allocation of state resources and make government more results-oriented.

Users can now search for data by fiscal year, program area, agency, and program name, and data may be viewed in various formats. Users can find the answers to questions such as: How much does the state spend on education? How many environmental cleanup projects were completed? How many women were screened for breast cancer?

The website contains searchable PARs back to fiscal year 2002, and the archives allow users to review published PARs back to fiscal year 1999.

To access the new interactive Public Accountability Report, please visit <https://par.illinoiscomptroller.gov/>. ■



Illinois' Minimum Wage Increasing to \$15 in 2025



MINIMUM WAGE

On February 19, 2019, Governor JB Pritzker signed into law Senate Bill 1, legislation that will gradually increase Illinois' minimum wage to \$15 an hour between January 2020 and January 2025.

The graphics below provide perspective on the history of Illinois' minimum wage and how its rate compares to other states.

–ILLINOIS–

Minimum Wage Over The Years

1972	\$1.40	1997	\$4.75
1976	\$2.10	1998	\$5.15
1979	\$2.30	2004	\$5.50
1984	\$2.65	2005	\$6.50
October 1984	\$3.00	2007	\$7.50
July 1985	\$3.35	2008	\$7.75
1991	\$3.80	2009	\$8.00
1992	\$4.25	2010	\$8.25

Minimum Wage Increase Schedule Under Public Act 101-0001 (Senate Bill 1)

January 2020	\$9.25
July 2020	\$10.00
2021	\$11.00
2022	\$12.00
2023	\$13.00
2024	\$14.00
2025	\$15.00

Sources: Illinois Department of Labor, Public Act 101-1001

Current Minimum Wage Rates in States with Populations of at Least 10 Million

New York: \$11.10
California: \$11.00
Ohio: \$8.55

Florida: \$8.46
Illinois: \$8.25
Georgia: \$7.25*

North Carolina: \$7.25*
Pennsylvania: \$7.25*
Texas: \$7.25*

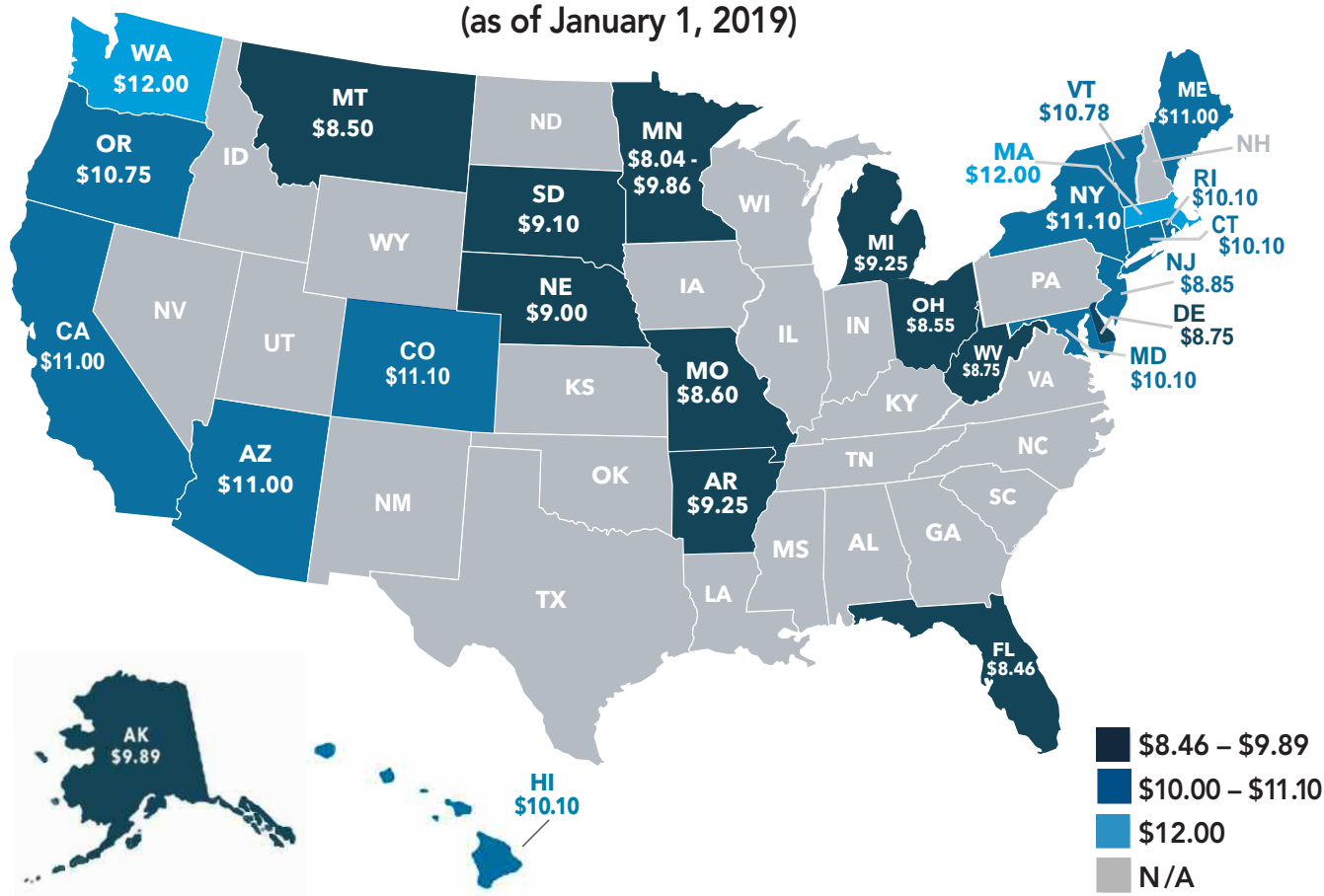
*Matches federal minimum wage rate.

Sources: U.S. Department of Labor; U.S. Census Bureau

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States with Minimum Wage Rates Higher than Illinois'

(as of January 1, 2019)



The following states have planned minimum wage increases after January 1, 2019:

- Arizona:** \$12.00 in 2020
- Arkansas:** \$10.00 in 2020; \$11.00 in 2021
- California:** \$12.00 in 2020; \$13.00 in 2021; \$14.00 in 2022; \$15.00 in 2023
- Colorado:** \$12.00 in 2020
- Delaware:** \$9.25 in October 2019
- Maine:** \$12.00 in 2020
- Maryland:** \$11.00 in 2020; \$11.75 in 2021; \$12.50 in 2022; \$13.25 in 2023; \$14.00 in 2024; \$15.00 in 2025
- Massachusetts:** \$12.75 in 2020; \$13.50 in 2021; \$14.25 in 2022; \$15.00 in 2023
- Michigan:** \$9.45 in March 2019
- Minnesota:** \$11.00 in July 2019 for employers with 100 or fewer employees
- Missouri:** \$9.45 in 2020; \$10.30 in 2021; \$11.15 in 2022; \$12.00 in 2023
- New Jersey:** \$10.00 in July 2019, and \$1.00 per year until \$15.00 in 2024
- New York:** \$11.80 in 2020; \$12.50 in 2021; thereafter, adjusted annually for inflation until \$15.00
- Oregon:** \$11.25 on July 1, 2019; \$12.00 in 2020; \$12.75 in 2021; \$13.50 in 2022
- Washington:** \$13.50 in 2020

Sources: U.S. Department of Labor, Consolidated Minimum Wage Table; GTM Payroll Services; National Conference of State Legislatures

Debt Transparency Act Report: March Ended with Estimated \$8.653 Billion Bill Backlog

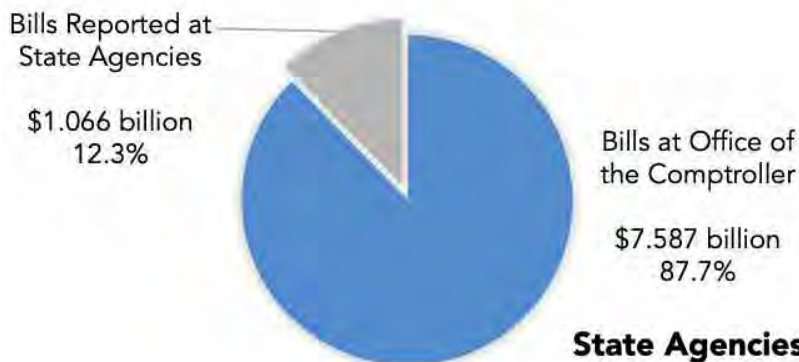


For the reporting period ending March 31, 2019, state agencies reported nearly \$363 million in General Funds liabilities and late payment interest penalties. This amount reflects liabilities that have not yet been sent to the Office of the Comptroller but are eligible to be sent because the agency has an approved invoice or pending interest payments.

Reporting agencies' total unpaid bill backlog, based on their General Funds and Health Insurance Reserve Fund (HIRF) liabilities, including late payment interest penalties owed on bills released for payment by the Office of the Comptroller, totaled \$1.066 billion for the March 2019 period, representing an increase of \$133 million compared to agencies' February 2019 liabilities. This \$1.066 billion has been incorporated into the estimated backlog of bills reported daily on the Comptroller's website and will remain as static input to this calculation until the next DTA monthly report.

Estimated General Funds Bill Backlog

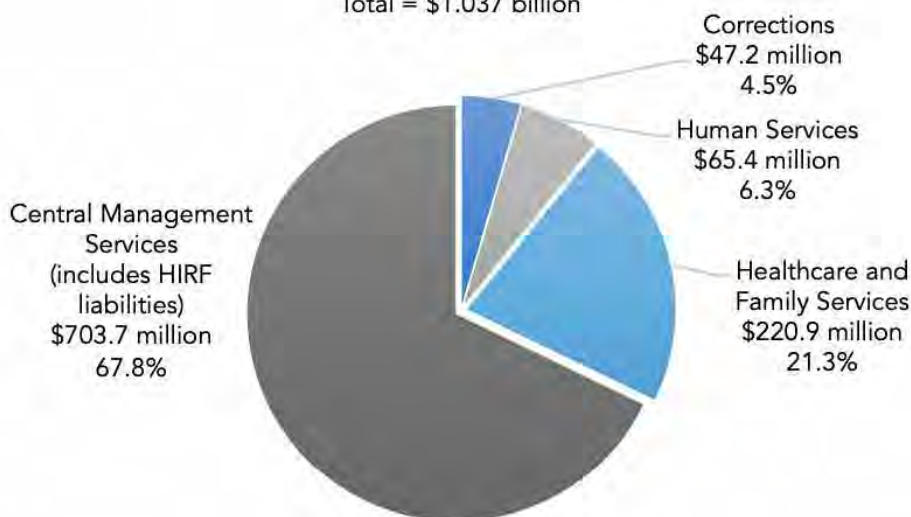
as of March 31, 2019
Total = \$8.653 billion



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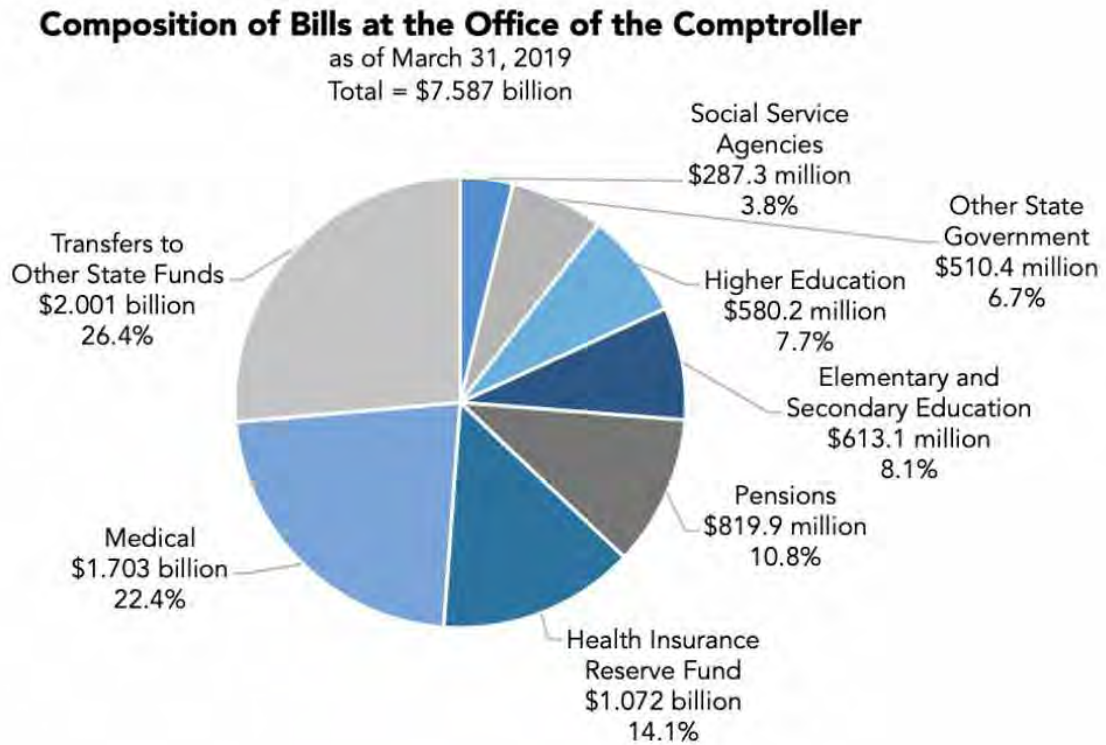
State Agencies with Largest General Funds/HIRF Liabilities

Includes Late Payment Interest Penalties
as of March 31, 2019
Total = \$1.037 billion



Combining this \$1.066 billion with the \$7.587 billion in bills at the Office of the Comptroller results in a total estimated General Funds and HIRF bill backlog for March 31, 2019 of \$8.653 billion, an increase of more than \$91 million from the end of February 2019.

For more information on the state's monthly estimated bill backlog, please review monthly Debt Transparency Reports on the Office of the Comptroller's website. ■



Featured Vendor: The Chicago Lighthouse



Illinois Comptroller Susana A. Mendoza travels the state to meet with vendors who suffered through sparse or no payments during the two-year state budget impasse. On these visits, she hears how delayed payments caused by Illinois' bill backlog, which was an adjusted \$8.195 billion in mid-April 2019, have left many of them struggling to pay their employees and, for some, struggling to keep their doors open.



The Office of the Comptroller does as much as it can to expedite payments to vendors undergoing financial hardship so they can continue the critical work they are doing and keep their employees on the job.

Each issue of *Fiscal Focus* will highlight one of these vendors so readers can learn more about the impact the state's bill backlog has on people's lives and on businesses and non-profits throughout Illinois.

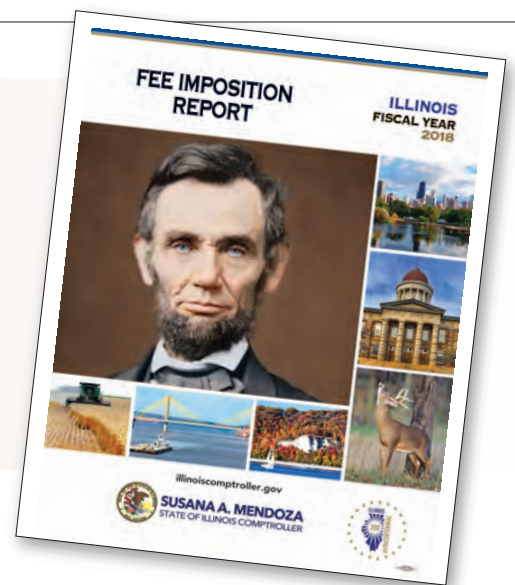
The featured vendor for this *Fiscal Focus* is the Chicago Lighthouse, a social service provider

that serves the blind, disabled, visually impaired, and veteran communities. The Chicago Lighthouse, founded in 1906 on Chicago's West Side, provides services, including clinical vision care, employment opportunities, education, and vocational training, to more than 67,000 people each year.

When Comptroller Mendoza visited the Chicago Lighthouse in November 2018, she listened to staff members' concerns about payment delays and worked with them to expedite needed funding. The visit included a tour of the facility with President and CEO Janet Szlyk and meetings with the dedicated staff and their appreciative clients. Comptroller Mendoza saw the Clock Factory, which employs individuals with disabilities, and she was featured on CHRIS Radio, a program produced by Lighthouse staff members that provides readings of newspapers and periodicals for listeners with a wide range of disabilities. Comptroller Mendoza promised she would do everything she can to keep the Lighthouse brightening the lives of those it serves. ■



New in Fiscal and Financial Reports: Fee Imposition Report



The Office of the Comptroller produces more than 20 different reports on various aspects of the state's finances, including monthly reports on revenues and expenditures, annual reports detailing budget appropriations, and annual reports on the state's bonded indebtedness.

In this issue, we highlight the *Fee Imposition Report*.

State agencies are required to submit to the Office of the Comptroller annual information on

the fees they are responsible for collecting. Revenue from fees the State of Illinois is directed to collect helps support many of the state's functions and responsibilities. Fees generated are devoted to a variety of areas, including law enforcement, health care, conservation, veterans, and education.

Each year, the Office of the Comptroller reviews the fiscal impact of these fees on the state and its taxpayers and presents the information in a *Fee Imposition Report*, which includes a summary of

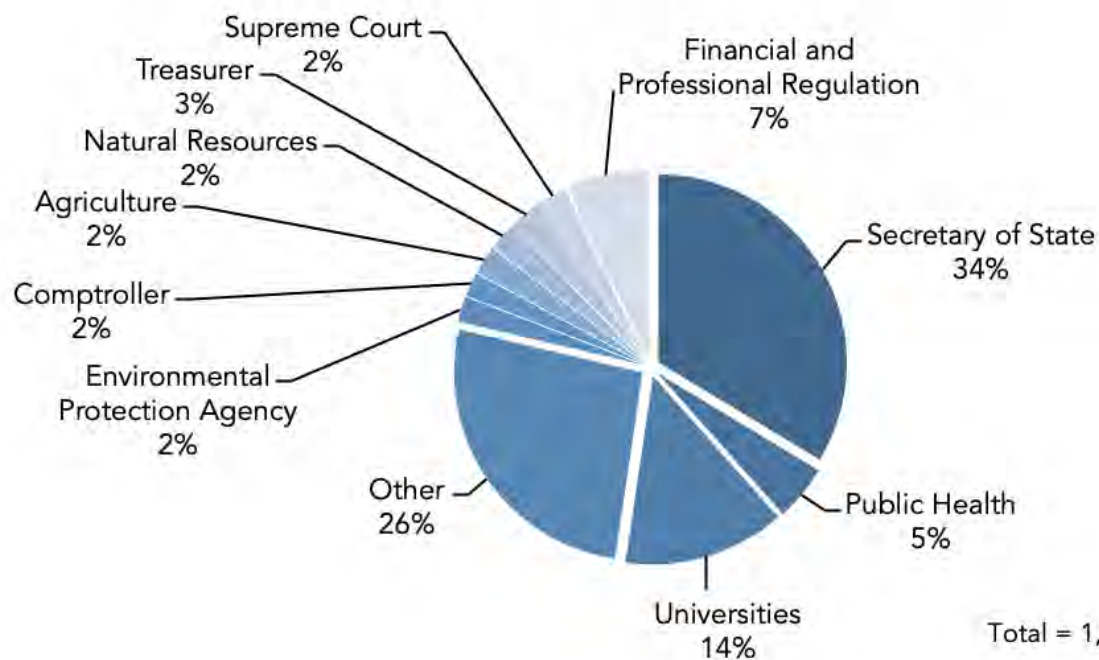
the fees collected during the preceding fiscal year, the revenues they generate, and an analysis of the fees as reported to the Comptroller by state agencies and other entities.

Highlights of the Fiscal Year 2018 *Fee Imposition Report* include:

- A total of 1,561 fees were counted among the agencies, with 97 agencies reporting \$9.835 billion in revenue generated.

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Percentage of Fees by Agency Reporting Fiscal Year 2018



- The top 10 revenue-generating fees accounted for two-thirds of the total fee revenue for the fiscal year, generating \$6.6 billion.
- In fiscal year 2018, fees generally paid by individuals accounted for 38% of all fees and 60% of total fee revenues, while those generally paid by organizations accounted for 43% of all fees and 39% of total revenues.
- The Hospital Provider fee, collected by the Department of Healthcare and Family Services, was the largest grossing fee, generating \$1.4 billion, or 14% of the state's total fee revenue. The department also administers the County Hospital Services Provider Participation fee, which generated nearly \$746 million for the fiscal year, and the Long-Term Care Provider – Occupied Bed Assessment, which generated more than \$138 million. These three fees account for just over 27% of the top 10 largest fees, and 73% of the total fees for the Department of Healthcare and Family Services.
- The State Toll Highway Authority collected the second-largest fee revenues at \$1.3 billion. Tolls collected by the Authority make up almost 14% of the state's total fee revenue.
- The Secretary of State's office collects the Registration fee for First Division Motor Vehicles, generating more than \$900 million in fiscal year 2018. This fee makes up a majority of the motor vehicle registrations because it is the most common type of vehicle (one designed to carry 10 or fewer people). The Secretary of State also collects the Certificate of Title fee, which generated nearly \$181 million. The revenue from the Certificate of Title fee is deposited into several funds, including \$84 million to the Road Fund, \$49.3 million to the State Construction Account Fund, and \$27.1 million to the General Revenue Fund. ■

To review the full *Fee Imposition Report* for fiscal year 2018, please visit the Comptroller's website at illinoiscomptroller.gov and select "Find A Report".



- The Illinois Comptroller's Office processed 3,949,635 tax refunds in fiscal year 2018.
- The Illinois Comptroller's Office has a mail-sorting machine that can sort 45,000 pieces per hour.
- There are currently 741 active state funds (fiscal year 2019).
- Fiscal year 2018 base revenues into the General Funds totaled \$40.9 billion, with 43.3% coming from individual income taxes and another 19.1% coming from sales tax.
- According to the Commission on Government Forecasting and Accountability (CGFA), in 2012, nearly all the \$1.651 billion in state gaming revenues came from Illinois riverboats. By 2018, casino revenues had fallen to \$1.375 billion. However, video gaming terminals in Illinois more than made up this difference, accounting for \$1.5 billion of the \$2.875 billion in total gaming revenues. When combined, revenues generated from these gaming formats had increased by more than \$1.2 billion, or 74.1%.

FISCAL FOCUS

Fiscal Focus is one of the ways the Comptroller's Office strives to assist taxpayers and the people of Illinois. This report is designed to provide fiscal information of general interest.

Fiscal Focus is published by the Illinois Office of the Comptroller Susana A. Mendoza, 201 State House, Springfield, Illinois 62706. Questions or comments may be directed to (217) 782-6000.

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